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SUBSTANCE ABUSE REHABILITATION PROGRAM (SARP)

PRESCRIPTION VERIFICATION AND MEDICAL NECESSITY FORM

To the Practitioner of the Substance Abuse Rehabilitation Program (SARP) Participant:
Please complete this form and submit to the SARP Program ***within ten (10) days of providing services to the SARP Participant****. You may fax to (617) 887-8786. The original completed form must be mailed. If you have any questions, please call the SARP Confidential phone line at (617) 973-0904.*

Name of SARP Participant (print):_____
Date of Treatment: _____
Diagnosis: _____
Follow up Appointment Date (if not applicable please indicate with N/A):_____

Prescription Information

DATE OF PRESCRIPTION	TYPE OF MEDICATION	QUANTITY & DOSAGE PRESCRIBED NUMBER OF REFILLS	RATIONALE FOR MEDICATION (if additional space is needed please attach to this form)

I attest that I am aware that the above-named patient is enrolled in the SARP program and I have reviewed their Consent Agreement for SARP Participation, including unauthorized medications.

Practitioner Name (print)_____ License No._____

Address and Phone No._____

Practitioner Signature:_____ Report Date_____